

Iowa Board of Nursing

RiverPoint Business Park
400 S.W. 8th Street Suite B
Des Moines, IA 50309-4685

FORM A – Submitted by a qualified professional with expertise in the area of the diagnosed disability or interpretation of results.

**RE: INDIVIDUALS WITH DISABILITIES WHO REQUEST SPECIAL TESTING
ACCOMMODATIONS DURING ADMINISTRATION OF THE NATIONAL COUNCIL
LICENSURE EXAMINATION FOR REGISTERED NURSES AND LICENSED
PRACTICAL NURSES [NCLEX®]**

Pursuant to the Iowa Administrative Code [655] 3.4(5) licensure applicants with disabilities, as defined in the Americans with Disabilities Act, may be provided modifications in the examination or examination administration. In order to be considered documentation of the applicant's disability and need for testing modifications, including results of diagnostic testing when appropriate, must be submitted to the board by a qualified professional with expertise in the area of the diagnosed disability or interpretation of results. Documentation must include all of the items listed below to justify the candidate's need for modifications due to a disability that substantially limits one or more major life activities.

Please complete this form or attach it to your narrative comments. The forms may be returned directly to the Iowa Board of Nursing office or returned to the applicant for submission. Receipt of this form and the appropriate supporting documentation is required for board consideration of testing accommodations.

[1] NAME OF PATIENT/CLIENT

[2] CLINICAL DIAGNOSIS OF DISABILITY BY TITLE AND CODE NUMBER

[3] HISTORY OF THE DISABILITY

[4] PAST ACCOMMODATIONS AND DESCRIPTION OF IMPACT ON FUNCTION

[5] NAME AND DATE OF SPECIFIC STANDARDIZED AND PROFESSIONALLY
RECOGNIZED TESTS/ASSESSMENTS [e.g. Woodcock-Johnson, Weschler Adult Intelligence Scale]

[6] SCORES RESULTING FROM TESTING

[7] INTERPRETATION OF SCORES AND EVALUATIONS

[8] RECOMMENDATIONS FOR TESTING ACCOMMODATIONS WITH A STATED
RATIONALE ADDRESSING WHY THE ACCOMMODATION IS NECESSARY
AND APPROPRIATE FOR THE DIAGNOSED DISABILITY

[9] SIGNATURE, CREDENTIAL AND TITLE OF DIAGNOSTICIAN OR QUALIFIED
INDIVIDUAL WHO HAS INTERPRETED THE DIAGNOSTIC TEST RESULTS
[Please include telephone number.]